CONCEPT ANALYSIS

A concept analysis of watchful waiting among providers caring for women in labour

Nicole S. Carlson & Nancy K. Lowe

Accepted for publication 8 June 2013

Abstract
Aim. This paper is a report of an analysis of the concept of watchful waiting.
Background. Little is known about differences between the intrapartum care processes of midwives and physicians. In this time of growing rates of surgical birth outcomes, intrapartum care processes are a key area for research and improvement. Watchful waiting is a common care plan used by both midwives and physicians that involves the timing of interventions in labour.
Design. Rodgers' Evolutionary Model was used to conduct a concept analysis of the term watchful waiting.
Data sources. Scientific literature authored by, and about, midwives and physicians, as located via an intrapartum-focused database search inclusive of years 1922–May 2012. Thirty English-language articles from nine different countries were located, representing the midwifery and physician scientific literature focusing on watchful waiting in labour and provider decision-making processes.
Review method. Attributes, consequences, antecedents and affecting themes were identified through a thematic analysis of the identified articles.
Results. Data analysis reveals that many midwives and physicians define watchful waiting differently, based on their philosophies of care.
Conclusion. The care of women in labour is complicated as a result of different understandings by some providers of common processes of intrapartum care.

Keywords: intrapartum, labour, midwife, physician, provider, watchful waiting

Introduction
The developed nations of the world have seen a sharp rise in the number of women who end their pregnancies with caesarean delivery in the past 20 years, with current caesarean delivery rates over 30% in many countries (Lauer et al. 2010, Lumbiganon et al. 2010, Luz et al. 2010, Menacker et al. 2010) and over 50% in some markets with private insurance (Rebelo et al. 2010, Patah & Malik 2011). This trend has occurred despite repeated recommendations from the World Health Organization for total caesarean rates to stay between 10–15% (Lauer
et al. 2010). The process of labour management by women’s healthcare providers is identified as a source of substantial variation in caesarean rates (Hanley et al. 2010) and therefore as a key area for improvement in the caesarean trend. Most investigations of the intrapartum process of care, to date, have focused on which interventions are used in women’s labours, rather than analysing when interventions are used by providers (Davis et al. 1994, Albers et al. 1997, Jackson 2003, Smyth et al. 2007, Hatem et al. 2008, Nguyen et al. 2009). However, the timing of interventions in labour has been shown to be important in women’s risk for eventual caesarean delivery, with most caesareans performed for the indication of labour dystocia, or ‘abnormally slow labor’ (Gifford et al. 2000, Jackson 2003, Abenhaim & Benjamin 2011).

The use of more liberal timelines in intrapartum management is associated with lower caesarean delivery rates (Olatunbosun et al. 2002). Collaborations between physicians and nurse-midwives are known to produce lower rates of caesarean delivery when compared with physician-only management of labour, while maintaining neonatal outcomes that are similar (Davis et al. 1994, Fullerton et al. 1996, Hatem et al. 2008, Shaw-Battista et al. 2011). Midwives are more likely than obstetricians to delay hospital admission and to avoid or delay the use of technological interventions like synthetic oxytocin administration, artificial rupture of membranes and epidural (Jackson 2003, Reime et al. 2004, Johantgen et al. 2011). Especially low rates of caesarean are seen in practices using liberal labour timelines within the midwifery context of care (Davis et al. 1994, Leeman & Leeman 2003, Shaw-Battista et al. 2011), although few studies have examined the specific process of intrapartum care present within a midwifery context (Kennedy & Lyndon 2008, Johantgen et al. 2011). Of course, not every midwife incorporates more liberal timelines in labour, just as not every physician practises with more conservative timelines. However, the significant differences found in multiple studies on intervention timing and labour outcomes, predicted by provider profession, point to the question of why many midwives manage labour differently from many obstetricians.

This concept analysis focuses on the term watchful waiting. This term is commonly used by both midwives and obstetricians with reference to intrapartum processes. However, watchful waiting can mean different things to different providers. This concept analysis will attempt to clarify the concept of watchful waiting within the two professions of medicine and midwifery.

**Background**

The term watchful waiting has been used in the healthcare setting as far back in history as scientific literature databases extend and is defined as ‘a policy of taking no immediate action with respect to a situation or course of events, but of following its development intently’ (Merriam-Webster 2012). The concept of watchful waiting in labour is one that is discussed by physicians and midwives in both clinical settings and in scientific literature (Bolaji & Meehan 1993, Barrett et al. 2009, McCourt 2009c, Jordan & Farley 2008, Kennedy & Lyndon 2008, Rayment 2011). Both types of professionals often work in the same birth settings and frequently are involved in discussions of intrapartum processes around collaborative efforts. However, physicians and midwives come from different educational programmes and may have different philosophies of care as a result. Individual physicians or midwives may adhere to a philosophy of care for women that is outside their profession, but the philosophy of professional origin supplies important context for most intrapartum providers as they think and talk about labour management (Bryers & van Teijlingen 2010). If midwives denote something different when they talk about watchful waiting from what a physician understands when using the same term, the resulting confusion has wide-ranging implications for interdisciplinary cooperation and optimization in intrapartum care. Just as important as labour management is the use of watchful waiting as a concept in research and scientific discourse around intrapartum care processes. It is therefore important that the concept of watchful waiting be clarified as it is used by midwives and physicians around intrapartum processes of care.

This concept analysis of watchful waiting uses Rodgers’ Evolutionary Model to better understand areas where disciplines agree and disagree about a term (Rodgers & Knaff 2000). Rodgers’ method was chosen for several reasons: first, the evolutionary concept analysis involves a rigorous analysis that involves inductive inquiry that is rooted in a particular realm for data collection. For this concept analysis, the scientific literature of midwifery and medicine was used as data in the attempt to develop clarity on the meaning of watchful waiting across these professional disciplines. Second, Rodgers’ method emphasizes the importance of context in the analysis of a concept. This analysis of watchful waiting as used in the scientific literature of these two professions clarified the origin of the concept and the values and perspectives of the two professions through their use of the concept. Third, Rodgers’ evolutionary method of concept analysis is a first step in the development of a concept.
that is of interest to nursing and allows for future research that classifies and characterizes phenomena.

**Data sources**

Data were collected for this concept analysis through a search of the scientific literature on watchful waiting. This search was conducted using the term watchful waiting to survey indexed literature for the broad healthcare use of the term within the context of pregnancy and birth (Rodgers & Knafl 2000). For the purposes of this concept analysis, no date range exclusions were used, as one goal of the analysis was to trace the historical use of the term. Depending on the database used, publications as early as 1922 were accessed in these searches (1922–2012). This literature search was limited to English language, with studies from any country included.

Literature searches were conducted using Pubmed, CINAHL, Ovid/MEDLINE and Google Scholar databases in May 2012. Pubmed and Ovid/MEDLINE databases were used to identify medical scientific literature. The CINAHL database was used to identify any nursing or midwifery literature not already captured through the other databases. Finally, Google Scholar searches were used to access book chapters, social science literature, more midwifery literature and thesis work on the concept. No attempt was made to search the popular literature for use of the concept watchful waiting because this concept analysis concerns the use of the concept by professionals, not the recipients of care. Social science literature was accepted if the subject of the article was physicians or midwives in intrapartum settings.

The literature survey used search term of ‘watchful waiting’ as all-text cross-searched against the secondary search all-text term of ‘labor’ or ‘labour’ for the inclusive dates 1922–2012 (Figure 1). Duplicates were discarded and articles were screened for content. After screening, articles were discarded if they did not address labour care. Full-text copies of all remaining articles were obtained through online proxies or library reserve.

Reverse citation searching on several key articles located foundational work on the concept of watchful waiting (Simonds 2002, Oakley 2004, van Teijlingen 2005, McCourt 2009a). Other additional articles focused on the healthcare use of the term watchful waiting were located via the survey of the literature (Penson 2009, Driffield & Smith 2007, Nelson et al. 2009, Elkin et al. 2004, Rosenbaum 2011, Hemmerich et al. 2012). Although these articles did not specifically address labour care, they were included in this concept analysis secondary to their focus on medical decision-making in general.

Once obtained, articles were separated by professional source of primary author and read a first time to identify

---

**Figure 1** Focused literature search of watchful waiting.

how the concept of watchful waiting was used in the article. A few articles were discarded at this final stage that did not discuss, nor use, the concept of watchful waiting in any significant way (Figure 1). Articles were then read a second time, coded by the components of the concept identified in each (attributes, antecedents, consequences, affecting factors) and analysed for major themes in accordance with the methodology outlined in Rodgers’ evolutionary model (Rodgers & Knafl 2000). Articles were also analysed for their use of terms associated with watchful waiting to create a picture of the mental cluster surrounding the concept.

Sample for analysis

The final sample included 30 studies with publication dates ranging from 1993–2012 (Table 1). Sixteen of these articles were authored by physicians, seven by nurses or midwives and seven by sociologists, anthropologists or statisticians. Thirteen of the 30 of the studies were published in the past two years (2010–2012). Among the medical articles, the majority (10/16) originated from Europe (Netherlands, Sweden, UK, Ireland, France, Italy) with the rest (6/16) from the USA. With the exception of one article discussing watchful waiting in an intrapartum setting (Scott 2005), all of the medically authored articles about watchful waiting in labour were from outside the USA. Most of the midwifery or nursing literature originated from the USA (5/7), with additional work from the UK and New Zealand. The majority of the social science work originated in the UK (4/7), with the remaining articles coming from the USA.

Results

Related and surrogate terms

Several terms were found in the included studies to be used in place of, or were suggested to be better descriptions than, watchful waiting to describe labour management. Medical literature tended to emphasize the importance of repeated monitoring during periods of watchful waiting and as a result gravitated towards terms that were felt to better describe this action on the part of the physician. ‘Watchful monitoring’ (Barrett et al. 2009), ‘expectant management’ (Boers et al. 2010, Jangsten et al. 2011, Maso et al. 2011, Torre et al. 2012) and ‘expectant monitoring’ (Vijgen et al. 2010) were used as surrogate terms (Rodgers & Knafl 2000) for watchful waiting in the medical literature. As was mentioned in Penson’s 2009 article, watchful waiting was used as a management option for early-stage prostate tumours starting in the early 1990s, resulting in the perception by many physicians that it is not enough to wait – the doctor must be doing something, in addition to postponing surgery, with a patient (Penson 2009). Penson proposed the term ‘active surveillance’ to better capture medicine’s active vs. passive nature while managing patients.

& Knafl 2000) found in the literature include ‘supportive care’ and ‘therapeutic presence’ (Jordan & Farley 2008, Romano 2009).

Attributes

A diagram of the components of the concept watchful waiting in a labour setting was built using themes collected from the included articles in this analysis (Figure 2). Each component of the concept is presented in the diagram and in discussion below, with themes identified for both midwives and physicians. Attributes are the essential part of the concept analysis, involving the ‘breaking apart of a thing to identify its constituent components’ (Rodgers & Knafl 2000). Analysis of the data identified three themes describing what the provider does, where the provider is located and the source of action during periods of watchful waiting in labour.

The first attribute of watchful waiting during labour by a provider describes what is being done. For physician-authored literature, watchful waiting describes a period when the patient is observed with periodic testing for the progression of an illness while deciding if immediate curative treatment is warranted (Driffield & Smith 2007). In pregnancy, watchful waiting typically includes regular, repeated examinations to assess for changes, laboratory testing, continuous foetal monitoring and occasionally imaging studies (Nelson et al. 2009, Elkin et al. 2004, Barrett et al. 2009, Maso et al. 2011). In contrast, identified literature included a midwifery philosophy of care that interprets watchful waiting as the provider’s observation of the labouring woman’s behaviour, emotional state and

Figure 2 Concept analysis of watchful waiting as used by midwives and physicians in labour.
environment. Repeated vaginal examinations are discouraged, as they can be uncomfortable and upsetting to women, thus hindering labour progress (Rayment 2011). Literature about midwifery care also expressed the idea that labour progress can usually be accurately tracked through the woman’s behaviour, thus making internal examinations unnecessary except in cases of ‘mixed signals’. Foetal monitoring is continued, but it is carried out intermittently to allow for the woman’s unrestricted movement in labour (Romano 2009). Laboratory and imaging tests are not mentioned as part of a period of watchful waiting within a midwifery approach to labour care. Verbal and physical support is provided by the midwife in keeping with her ‘therapeutic presence’ in the woman’s labour from the understanding that the midwife can help a woman correct labour problems by offering the support forged through a trusting relationship.

The second attribute involves the ‘where’ of the provider during a time of watchful waiting. Physician-authored literature advocated physical separation from the patient to allow for objective assessment of change during the period of surveillance. By virtue of the fact that the patient is being left without direct medical supervision, it is assumed that she is appropriate for either self-care or care by the inpatient nurse during periods of watchful waiting (Boers et al. 2010). In contrast, the midwifery perspective expressed by authors emphasized the importance of the provider’s ‘therapeutic presence’ during periods of watchful waiting in labour (Jordan & Farley 2008, Winter & Duff 2009). Therapeutic presence is described as the provider sitting with the woman, often not talking to her, but offering comfort as needed and creating an ‘atmosphere of calm’ (Rayment 2011). Simonds (2002) also emphasized the importance of this calm presence during watchful waiting to promote normal labour progress.

The final attribute is the source of action during periods of watchful waiting in labour. Analysis of medical literature depicts action performed by the provider on the patient (Boers et al. 2010, Shennan & Hezelgrave 2010, Vijgen et al. 2010, Maso et al. 2011). Active surveillance involves the provider (or the nurse who carries out the provider’s orders) entering and leaving the labour room, with visits bringing moments of decision by the provider as to the plan of care. The provider is active, rather than passive (Penson 2009). Importance is placed on normal labour progress, with regular interventions being required in the form of vaginal examinations to track this progress (Simonds 2002). From a midwifery perspective, periods of watchful waiting have the woman’s action at their centre (Jordan & Farley 2008, Romano 2009). Because the provider practising from this perspective stays nearby during watchful waiting, her entrance and exit is not associated with surveillance. Although the midwife stays vigilant for signs of complications in labour, emphasis is on the provider being present with the woman and having the potential to act only when necessary (Rayment 2011).

Antecedents

Physician and midwifery literature also differed in antecedents to watchful waiting. The first major antecedent to watchful waiting identified was the provider’s view of labour normality. Physicians tended to take the perspective that labour processes are often abnormal enough to require intervention, while midwives believed the opposite – that labour was inherently normal and could be left to proceed without any intervention except in rare cases (Bryers & van Teijlingen 2010). For example, Boers et al. (2010) recommend induction of labour when discussing the implications of their clinical study (which showed no difference in immediate outcomes between watchful waiting for labour vs. induction of labour in the mothers of intrauterine growth-restricted babies), even after pointing out a previous study showing some long-term neurological protective effect on children whose mothers were allowed to wait for labour. This recommendation is logical in light of the medical view that ‘the normal condition is now the ‘experiment’ and the intervention is the ‘control’ in perinatal care’ (Romano 2009). In contrast, the literature presented midwifery beliefs that childbirth is a natural physiological event and that most pregnant women will require little or no medical intervention to have a normal and safe birth (Oakley 2004).

A second antecedent is the provider’s view of mind/body interaction. Physician-authors discussed labour from a biological, cause-and-effect perspective, where mind and body act independently of one another (Boers et al. 2010, Davis & Walker 2010, Maso et al. 2011). Literature about midwives presented the view of progress during labour as a result of hormonal, physiological and psychological interactions between the mother, her baby and the greater environment (Downe & Dykes 2009).

Labour progress is another key antecedent of watchful waiting among providers. Physician-authored literature presented labour progress and outcomes as something that can be generalized from woman to woman, forming the basis of evidence-based medicine (Boers et al. 2010, Jangsten et al. 2011, Maso et al. 2011). Some midwifery literature also presented this perspective, making recommendations for clinical practice based on these generalizations (Brucker
Other midwifery literature presented an alternative view that each woman’s labour is unique, referring often to the importance of considering the individual woman in assessment of labour (Downe & Dykes 2009, Davis & Walker 2010).

Finally, physician and midwifery perspectives in the scientific literature differ on the watchful waiting antecedent of labour length. After her review of medical texts, sociologist Simonds (2002) concluded that physicians view slow labour progress as evidence of pathology. Women’s bodies are viewed within this perspective as ‘prone to error, but correctable’; however, strict time limits are presented as the primary way to monitor women for this correction to be applied (Downe & Dykes 2009). In contrast, midwife-focused articles reviewed here tended to view times of slower labour progress as a period of rest, when women can regroup energy (Simonds 2002). The process of labour is more important than how long it takes (Winter & Duff 2009).

Consequences
As a consequence of a period of watchful waiting, intrapartum providers anticipate different results. From a physician’s perspective, watchful waiting brings the possibility of several negative and one possible positive consequence (Figure 2). Physician-authors expressed concern that watchful waiting would result in healthcare inefficiency, with the related risk for more costly care stemming from surveillance costs (Driffield & Smith 2007). With the extensive surveillance required as part of most medical approaches to watchful waiting, monetary costs are often higher than immediate induction or surgery (Nelson et al. 2009, Shennan & Hezelgrave 2010, Viigen et al. 2010, Torre et al. 2012). Authors presented the perspective of some physicians, who do not see this increased cost as reason for avoiding watchful waiting or expectant management (Shennan & Hezelgrave 2010, Moriarty 2011). Related to the healthcare inefficiency, some physicians (Scott 2005, Shennan & Hezelgrave 2010, Torre et al. 2012) and midwives (Rayment 2011), who value clinical efficiency, referenced the unfair allocation of their time and effort among patients as a consequence of watchful waiting. Even more worrisome than inefficiency, however, was the perceived risk of litigation and poor outcome some of the physician-authored literature presents as a result of watchful waiting (Penson 2009, Boers et al. 2010, Rosenbaum 2011). The alternative to watchful waiting from a physician’s view is surgery or intense medication therapy (Bolaji & Meehan 1993, Elkin et al. 2004, Koblinsky et al. 2006, Maso et al. 2011, Torre et al. 2012). It is for this reason that providers practising from a conservative perspective see a positive consequence of watchful waiting in labour to be the deferral of a decision to allow time and more information that may cause avoidance of ‘expensive, irreversible, or risky treatments’ (Driffield & Smith 2007). Important in these provider’s decisions is the perceived risk of the woman undergoing surgery vs. remaining pregnant (McCourt 2009c).

Midwifery-focused scientific literature referred to different consequences of watchful waiting in labour from physician-focused literature, with most being positive. Watchful waiting was seen as an optimal approach to labour, with the best outcomes for the mother and baby the likely result (Koblinsky et al. 2006). Because watchful waiting is possible only with the close personal connection between midwife and labouring woman, an emotional connection between the two is also seen as a consequence of this practice in labour (Davis & Walker 2010). In the case of labouming women who do not readily accept the advice of the midwife, this emotional connection can be unpleasant to the midwife (Rayment 2011). Finally, midwife-focused literature emphasized the consequence of an enhanced experience for the woman. Because the practice of watchfully waiting for some midwives is based on their view that women are strong and normal in labour, midwives see a consequence of this practice as the woman’s experience of her own strength and capability through labour, thus preparing her for the challenges of motherhood (Oakley 2004, van Teijlingen 2005).

Affecting factors
Several factors emerged from the reviewed literature as factors affecting the relationship of watchful waiting antecedents to the attributes and consequences (Figure 2). Medical insurance companies, liability insurance, national guidelines and other outside organizations have the potential to change the way that watchful waiting is practised in a particular community or setting (Bryers & van Teijlingen 2010, Rayment 2011, Rosenbaum 2011). Both physicians and midwives felt that the setting where care is provided has a profound influence on watchful waiting practices (Jordan & Farley 2008, Rayment 2011, Rosenbaum 2011, Everly 2012). In settings that were not supportive of practices of watchful waiting, the providers admitted to practising sabotage by falsifying examination findings and reports (Simonds 2002, Rayment 2011). Providers practising in settings that did not support their practices could be subject to pressure from co-workers in the form of sanctions and bullying when their clinical decisions did not adhere to the workplace norm (McCourt 2009c). The individual
What is already known about this topic

- Intrapartum providers of different educational backgrounds may have different philosophies guiding their care of women.
- Intrapartum providers of different educational backgrounds can have different outcomes of care in matched samples of women.

What this paper adds

- The concept of watchful waiting is defined differently in some medical and midwifery scientific literature.
- Different definitions of watchful waiting arise from the divergent philosophical perspectives of some physicians and midwives around intrapartum care processes.
- Both physicians and midwives perceive the importance of affecting factors like third-party healthcare agencies, setting, healthcare team, provider anxiety and woman preference on the concept of labour management.

Implications for practice/policy

- Better understanding of the very different, discipline-specific uses of watchful waiting in labour is needed to prevent miscommunication between physicians, midwives and nurses who care for labouring women.
- Future research is needed to compare different processes and outcomes of labour management, including investigation of: provider physical presence with the labouring woman, labour interventions, influence of provider surveillance vs. presence in labour, impact of higher risk status women on provider’s management of labour, and how affecting factors like setting and provider anxiety impact labour management among birth providers.

approach of physicians, midwives and nurses assembled around labouring women was also seen as an affecting factor in the literature of watchful waiting (Jordan & Farley 2008, Kennedy & Lyndon 2008, Rayment 2011, Everly 2012). Some midwives could be more inclined towards a conservative approach to watchful waiting, while some physicians could practise with a more liberal approach.

Finally, the past experiences and preferences of the individual provider and labouring woman were discussed as factors affecting watchful waiting. Women who have strong preferences about their labour and birth can exert powerful influences on providers as they consider using watchful waiting (Bryers & van Teijlingen 2010, Everly 2012, Torre et al. 2012). Providers’ past experiences of poor patient outcomes can also evoke anxiety during labour management, with effects on judgement that are largely unrecognized by the providers themselves (Hemmerich et al. 2012). This anxiety could be especially potent in the work of providers who have had many past exposures to poor outcomes, including providers who are primarily trained in high-risk services, with little exposure to low-risk pregnancy and birth care.

Exemplar

Rodgers’ evolutionary method for concept analysis includes an exemplar taken from the surveyed literature of the concept. Given this concept analysis comparing a midwifery and medical perspective on timing in birth processes via watchful waiting practices, contrasting exemplars would be needed. However, no suitable exemplars of physician watchful waiting management were located.

Discussion

This concept analysis of watchful waiting as discussed in scientific literature from or about physicians and midwives was conducted to create new insight on the concept (Rodgers & Knafl 2000). The analysis reveals that most midwives and physicians envision very different things when they refer to watchful waiting in labour. Although first used by physicians, watchful waiting was adopted as a concept by midwives and refined to signify a fundamentally different activity. For many midwives, watchful waiting is defined as providing calm, non-invasive therapeutic support to a woman in labour, so as to facilitate her work. For many physicians, watchful waiting is defined as a period of observation undertaken to avoid immediate surgery while active surveillance of labour progress and maternal/foetal stability is enacted. The antecedents, attributes, consequences and affecting factors of watchful waiting, as revealed by the scientific literature, reflect a middle-range explanatory theory of this concept in these two disciplines (Figure 2). The use of this term in the scientific literature reveals the very different underlying theories held by some midwives and physicians regarding the care of women in labour. Physicians’ belief in objectivity, mind/body separation and labour abnormality leads many to regard ‘watchful waiting’ as a potentially inefficient, risky management choice undertaken to avoid intensive medical or surgical outcomes. On the other hand, midwives’ belief in subjectivity, mind/body connection and labour normality leads many of them to regard watchful waiting as an essential part of
their care, leading to optimal maternal/child health outcomes, emotional connection with the woman and an enhanced experience for the mother as she initiates new motherhood. Literature from/about both physicians and midwives identifies similar affecting factors on the concept of watchful waiting, including third-party healthcare influences, birth setting, healthcare team, woman’s preference and provider anxiety.

Limitations
Limitations of this concept analysis include the process for selection of the literature included as data. Themes important to the concept of watchful waiting may have been missed if some of the important scientific literature using this term was missed on database query. This analysis is also limited by the fact that a single person (NC) performed all reviewing, coding and thematic analysis. Optimally, having a second researcher perform a data analysis of this concept could have provided an opportunity for more discussion, bringing additional clarity to the process of theme identification.

Conclusions
This concept analysis of watchful waiting has important implications for clinical practice, research and education. Although the terms watchful waiting and surrogate expressions (expectant management, supportive care, etc.) are used frequently by providers when working with labouring women, this concept analysis reveals that very different activities are potentially being envisioned with these terms, depending on the provider’s background and philosophical perspective. The midwife and physician attributes of watchful waiting are different enough to result in significant miscommunication with the unexplained use of the term. Future work to further clarify this and other commonly used intrapartum care practices is needed to facilitate better interdisciplinary perinatal care.

Rodgers’ methodology was chosen because this analysis is intended to yield the development of knowledge through the adequate characterization of a phenomenon (Rodgers & Knafl 2000). This concept analysis of watchful waiting gives one view into the different care practices and philosophies of birth providers. Future research is needed to compare the effectiveness of different processes and outcomes of intrapartum care, including investigation of: provider physical presence with women in labour, components and outcomes of therapeutic presence in labour, emotional connection between woman/provider in labour, influence of surveillance (frequent vaginal examinations, etc.) on labour progress, impact of higher risk status women on provider’s management of labour (how does a provider’s belief in normal change with higher risk women?) and how affecting factors such as setting and provider anxiety impact labour management among birth providers.

Finally, this concept analysis illustrates the importance of intrapartum provider educational programmes. The physicians and midwives who authored, or were the subject of, the scientific literature surveyed for this concept analysis worked regularly with members of the other discipline, yet expressed very different perspectives of intrapartum care processes. The optimal care of women requires clear communication, truthful action and best practices. Different kinds of birth providers will better serve all women if they are educated with an understanding of the other provider’s perspective and work in healthcare settings that value them equally.

Acknowledgements
We thank Marie Hastings-Tolsma, PhD, CNM for her encouragement and dedication to nurse-midwifery.

Funding
Primary author was partially funded by grants from HRSA and the University of Colorado Denver’s ‘Touched by a Nurse’ scholarship during the process of conducting this analysis.

Conflict of interest
The authors have no conflict of interest to declare.

Author contributions
All authors have agreed on the final version and meet at least one of the following criteria (recommended by the ICMJE: http://www.icmje.org/ethical_1author.html):

• substantial contributions to conception and design, acquisition of data, or analysis and interpretation of data;
• drafting the article or revising it critically for important intellectual content.

References


Penson D.F. 2009 Active surveillance: not your father’s watchful waiting. Oncology 23(11), 980.


The *Journal of Advanced Nursing (JAN)* is an international, peer-reviewed, scientific journal. *JAN* contributes to the advancement of evidence-based nursing, midwifery and health care by disseminating high quality research and scholarship of contemporary relevance and with potential to advance knowledge for practice, education, management or policy. *JAN* publishes research reviews, original research reports and methodological and theoretical papers.

For further information, please visit *JAN* on the Wiley Online Library website: www.wileyonlinelibrary.com/journal/jan

**Reasons to publish your work in JAN:**

- **High-impact forum:** the world’s most cited nursing journal, with an Impact Factor of 1.477 – ranked 11th of 95 in the 2011 ISI Journal Citation Reports (Social Science – Nursing).
- **Most read nursing journal in the world:** over 3 million articles downloaded online per year and accessible in over 10,000 libraries worldwide (including over 3,500 in developing countries with free or low cost access).
- **Fast and easy online submission:** online submission at http://mc.manuscriptcentral.com/jan.
- **Positive publishing experience:** rapid double-blind peer review with constructive feedback.
- **Rapid online publication in five weeks:** average time from final manuscript arriving in production to online publication.
- **Online Open:** the option to pay to make your article freely and openly accessible to non-subscribers upon publication on Wiley Online Library, as well as the option to deposit the article in your own or your funding agency’s preferred archive (e.g. PubMed).